INTRODUCTION

This training manual has been prepared by staff from the Department of Community Health (DCH), Revenue and Reimbursement Division, for the purpose of assisting the qualified health plans (QHPs), their providers, community mental health services programs (CMHSPs) and any other party involved with Medicaid managed care to carry out their responsibilities related to third party liability. Revenue and Reimbursement is a division of the Bureau of Audit and Revenue Enhancement within the Budget and Finance Administration. Staff in this division have many years of experience with the pursuit of third party liability.

Information contained in this manual is organized and presented to allow users to quickly locate what they need. Separate sections have been included for the major categories of third party liability including health, casualty and parental liability. A section on data sharing describes information the State can provide to plans and providers, and ways that these entities can assist the State in maintaining accurate and current records of third party resources. Laws, regulations and other materials, which govern third party liability, are included as addenda. Also included are an index and glossary to make it easier to locate and understand specific terms and concepts.

The division will maintain a central registry of manual holders so that updates and revisions can be provided, as they become available. We welcome any suggestions or comments you have that may improve the content or design of this manual. You may fax your comments to Jackie Pirie at 517-335-8868, e-mail them to TPL@state.mi.us., or mail them to:

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AUTHORITY

In accordance with Title XIX Section 1902(a)(25) of the Social Security Act (addendum M) and Federal Regulation 42 CFR 433.135-139 (addendum N), the Medicaid program **must** pursue all liable third parties. The right of recovery is found under the Michigan Social Welfare Act 1939 PA 280 as amended; MCL 400.106(1)(b)(ii); MSA 16.490(16)(b)(ii) (addendum O). ***Health plans****, under provisions of the contract with the State,* ***are required to pursue payments from all liable third parties, with the exception of court ordered medical support expenses associated with childbirth.*** **By law, Medicaid is the payer of last resort.**

WHAT IS THIRD PARTY LIABILITY?

Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a member's medical coverage.

QHP RESPONSIBILITIES

Qualified health plans are contractually responsible for identifying and collecting third party liability information. When a third party is identified, it is the responsibility of the QHP to pursue payment and/or reimbursement from the liable source. Effective pursuit of all third party resources provides an opportunity to significantly increase cost savings and revenue. QHPs are contractually authorized to **retain all third party collections** with the exception of court ordered medical support expenses associated with childbirth**.**

BENEFICIARY RESPONSIBILITIES

As a condition of eligibility for Medicaid, beneficiaries **must** identify all third party resources unless they have 'good cause' (FIA Program Eligibility Manual 257, addendum K) for not cooperating. Private health insurance, workers' compensation insurance, no-fault auto insurance, and liability insurance are all potential resources that **must** be utilized. Failure to report these resources could result in the loss of a beneficiary's Medicaid eligibility (PEM 257, addendum K).

HEALTH INSURANCE INFORMATION

Private health insurance information obtained by the local Family Independence Agency (FIA) when a beneficiary applies for Medicaid is reported to DCH, Revenue and Reimbursement Division, and maintained in a central file. This information is verified and updated when Revenue and Reimbursement is notified of a change, addition or deletion of private health coverage. Beneficiaries and providers are primary sources of information regarding changes in coverage. All parties benefit from the availability of up-to-date private insurance records. Therefore, it is imperative that QHPs, providers and the State work collaboratively to collect and maintain **current** insurance information to ensure the most efficient use of state and federal funds.

CASUALTY INFORMATION

Requests for information regarding *paid* medical expenses are a major source of information concerning the existence of casualty cases. These requests come from attorneys, insurance companies, subpoenas, prosecuting attorneys and occasionally the beneficiary himself/herself. Information derived in this manner can be used to initiate an investigation for the potential *recovery* of medical expenses. Casualty related requests received by DCH are forwarded to the appropriate QHP for follow-up investigation and recovery.

CROSSOVER CASES

A crossover case involves an active casualty claim for a beneficiary who transitions between Medicaid fee-for-service (FFS) and a QHP(s). It will be necessary to maintain mutual cooperation between the Revenue and Reimbursement Division and the QHP(s) with regard to the settlement of a crossover case. DCH and the QHP(s) will need to notify one another of crossover claims and furnish current insurance and/or attorney information to assist in the recovery process. It is important to note that a crossover case may also involve expenses from more than one QHP due to movement between multiple QHPs.

HEALTH

INTRODUCTION

To minimize the use of federal and state funds for medical care costs, all other insurance resources **must** be utilized prior to Medicaid. **Medicaid is the payer of last resort** in accordance with Title XIX of the Social Security Act and Federal Regulation 42 CFR 433.138-433.139. ***Health plans***, under provisions of the contract with the State, ***will be payers of last resort.***

It is not uncommon for a Medicaid beneficiary to have some type of other health insurance. This section provides coordination of benefits information to assist QHPs in maximizing the utilization of other health insurance available to Medicaid beneficiaries.

IDENTIFICATION OF OTHER HEALTH INSURANCE

To effectively pursue payment for medical expenditures, it is imperative to identify potential insurance coverage(s) for **all** family members with each encounter. Along with health coverage, available benefits may include coverage for dental, vision, and pharmacy services. Coverage may differ for individual family members depending on the family make-up.

Potential sources of private health insurance coverage include:

- The patient's spouse's private health insurance
- The patient's spouse's employer/military benefits
- The patient's private health insurance
- The patient's employer/military benefits

If the patient is a minor, the source of coverage might be through a parent or absent parent, guardian, step-parent, or grandparent. It is particularly important to consider the absent parent of a minor child as a possible source of insurance.

Potential sources of private health insurance coverage for an **unborn child** include:

- If the mother is a minor, her parent's private health insurance
- The mother's own private health insurance
- The father's private health insurance

Providers should always question the beneficiary about the availability of additional insurance coverage during the initial and subsequent visits, and update their records on a regular basis.

Information regarding other insurance known to the State can be obtained from several sources. The State will provide other insurance information to the plans via the enrollment file and remittance advice. For the provider, the beneficiary's Medicaid card will list other insurance (OI) coverage known to the State.

QHPs and their providers should also check the availability of other insurance by using the dial-up ACCESS phone system (addendum B) or on-line ACCESS program, where available. ACCESS will provide updated insurance coverage with detailed information.

VERIFICATION OF OTHER HEALTH INSURANCE
Insurance information must be verified and documented. The following actions should be taken:

- Obtain policyholder's social security number, full name and birth date
- Obtain copies of the insurance cards (front and back)
- Obtain a copy of the Medicaid card
- Verify coverage and effective dates through the insurance company
- Identify covered and non-covered services available through the policy
- Verify insurance known to Medicaid by using the dial-up ACCESS phone system (1-800-723-8247, addendum B) or on-line ACCESS program, where available
- Verify BCBSM insurance coverage by accessing the DENIS or HART systems

REPORTING OF OTHER HEALTH INSURANCE
If private health insurance information is obtained that is not indicated on the ACCESS system, it should be reported to the Department of Community Health, Revenue and Reimbursement Division via form DCH-0402 (addendum A) by mail, e-mail, or fax to the addresses and phone numbers listed on the form. (Refer to Data Sharing section)

MEDICARE / MEDICAID DUAL ELIGIBILITY
When a patient is enrolled in both Medicare and Medicaid, **Medicare is the primary payer.** Enrollment in a qualified health plan is *voluntary* for an individual dually eligible for Medicare and Medicaid. The patient may be eligible for Medicare if he/she is:

- 65 years or older
- A disabled adult (entitled to SSI or RSDI due to a disability)
- A disabled minor child

When a Medicaid beneficiary reaches age 65, Medicaid will reject any claim received unless Medicare does not cover the service or the claim reflects Medicare payment. This policy applies, regardless of whether or not the beneficiary has applied for Medicare benefits. The only exception is for aliens who have not lived in the country long enough (5 years) to achieve Medicare eligibility.

Qualified health plans may reject claims in the same manner, and providers may deny non-emergency services to dual eligibles who are not enrolled in Medicare. Plans are encouraged to work with providers to address coordination of benefits issues involving Medicare, as well as assist enrollees in applying for Medicare benefits.

All beneficiaries, including those in a QHP, are sent a letter from the Medicaid Buy-In unit prior to their 65th birthday informing them of their obligation to apply for Medicare (addendum U). Beneficiaries who have concerns about out-of-pocket Medicare expenses should be encouraged to contact their caseworkers to determine eligibility for the Medicare Buy-In program. This is a program that allows Medicaid to pay a beneficiary's Medicare premium.

CO-PAYMENTS

Consistent with current contract language between the QHPs and the State, Medicaid beneficiaries enrolled in a QHP are **not** subject to co-payment requirements and **may not be charged** co-payments or other cost-sharing fees for covered services.

COMMERCIAL HMO/PPO OR MEDICARE HMO COVERAGE

Medicaid beneficiaries enrolled in a commercial HMO/PPO, or Medicare HMO are not eligible for enrollment in a QHP. If it is discovered that other insurance is available to a Medicaid patient through a commercial HMO/PPO or Medicare HMO, the QHP or their provider must notify the Department of Community Health, Revenue and Reimbursement Division via form DCH-0402 (addendum A).

CASUALTY

INTRODUCTION

Casualty insurance is primarily protection against loss relative to a personal injury. Casualty claims cover automobile accidents; job-related injuries; medical malpractice; trusts; restitution cases; and general liability claims which include slip and fall injuries, dog bites and product liability.

The qualified health plans have both an obligation and opportunity to significantly increase cost savings and revenue with the pursuit of recovery for casualty claims.

Federal Regulation 42 CFR 433.135-139 mandates the Medicaid program to pursue all liable third parties. The right of recovery is found under the Michigan Social Welfare Act 1939 PA 280 as amended; MCL 400.106(1)(b)(ii); MSA 16.490(16)(b)(ii). ***Health plans****, under provisions of the contract with the State,* ***are required to pursue payments from all liable third parties****.*

Requests for information regarding *paid* medical expenses serve as a source of information regarding the existence of a casualty case. These requests come from attorneys, insurance companies, subpoenas, and occasionally the beneficiary himself/herself. An additional source of information for potential casualty cases comes from a Trauma Edit Questionnaire (addendum E) used by the State. This computer-generated questionnaire is sent to Medicaid beneficiaries served under fee-for-service, when medical expenses for diagnosis codes ranging from 800.00 through 999 (with exceptions, addendum F) exceed a set threshold amount. QHPs may want to consider a similar questionnaire as a resource for gathering information to assist in the recovery of casualty related expenditures.

When a casualty case is identified by the QHP, it will be necessary to submit all pertinent information to the Department of Community Health, Revenue and Reimbursement Division via form DCH-0674 (addendum S) by mail, e-mail, or fax to the addresses and phone numbers listed on the form. This information will be stored in a DCH database for future reference to assist in the follow-up of individual cases in the event a beneficiary transfers from one QHP to another.

Pursuing casualty claims involves an investigation to determine the type of accident; identification of medical services related to the accident; identification of the liable party; assertion of liens (filing claims); documentation of the need for and justification of medical treatment received (medical records); and knowledge of pertinent laws. Certain claims may require legal action, initiated by the beneficiary, in order to prove negligence and the liability of a third party.

The following pages address specific types of casualty claims and some processes used to identify and pursue these claims.

MICHIGAN NO-FAULT LAW

INTRODUCTION

The Michigan No-Fault Law (addendum D), enacted October 1973, is designed to provide personal injury and property protection insurance for individuals involved in automobile accidents, ***without the burden of proving liability***. It requires all vehicles registered in the State of Michigan to carry basic automobile insurance.

Basic no-fault coverage includes Personal Injury Protection (PIP) and Property Protection Insurance (PPI). PIP covers all **medical services**, wage loss, replacement services, and burial expenses. PPI covers all property damage. Under the No-Fault Law, a person's own auto insurance is responsible for immediate coverage eliminating the need to prove negligence (fault).

The No-Fault Law covers all accidents occurring within the State of Michigan and all accidents occurring outside the state that involve a vehicle or person covered under a Michigan no-fault insurance policy.

This law also addresses injuries and property damage that occur when a vehicle is **uninsured.** It includes a provision for the establishment of the Assigned Claims Facility which provides financial help to individuals injured in an uninsured motor vehicle accident who have no insurance of their own.

"No-fault" benefits ***may be*** available to an injured person regardless of whether the injured person was at fault for the accident or whether the person was driving the car, was a passenger, or a pedestrian. To qualify for these benefits, certain criteria must be met**.** *If no-fault benefits are* ***not*** *available for a Medicaid beneficiary enrolled in a QHP, the QHP is responsible to pay for covered services.*

Pursuant to Medicaid policy (addendum G), if a claim has been filed and is contested, or liability is in question, the QHP must pay for the service and use the "pay and chase" method to pursue recovery from the third party.

The following pages provide a synopsis of the Michigan No-Fault Law and it's impact on health coverage provided by the qualified health plans.

[Items in brackets refer to specific sections of the No-Fault Law (addendum D).]

WHEN ARE NO-FAULT BENEFITS AVAILABLE?

The Michigan No-Fault Law, MCL 500.3105(1), states that benefits are payable for "accidental bodily injury arising out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle," regardless of fault. No-fault benefits are *not limited* to the customary "auto accident".

- **Ownership can be defined by any of the following** [3101(2)(g)]:
  - A person renting a motor vehicle or having possession of, or unlimited use of a motor vehicle, under a lease or other arrangement, for a period of more than 30 days
  - A person who holds legal title to a vehicle (other than for the business purpose of leasing motor vehicles)
  - A person who has the immediate right of possession of a motor vehicle under an installment sale contract

- **Operation/use of a motor vehicle may include** [3105]:
  - Standard transportation
  - Loading or unloading the vehicle
  - Entering or exiting the vehicle

- **Maintenance of a motor vehicle refers to**[3105]:
  - A private individual performing maintenance on a personally owned vehicle; i.e., changing a tire, changing the oil

- **An illegally parked vehicle when** [3106]:
  - Shown to be the *cause* of an accident, affords PIP coverage for the injured person(s)

- **An out-of-state vehicle when** [3101]
  - In the state of Michigan **more than 30 days**, registered in Michigan and meeting the insurance requirements under the Michigan No-Fault Law

WHEN ARE NO-FAULT BENEFITS NOT AVAILABLE?

There are situations when a person is injured as the result of a motor vehicle accident and is not eligible for no-fault benefits. When PIP benefits are not available, the QHP is required to pay for any covered services related to the accident. No-fault coverage is **not available** when one or more of the following circumstances occur:

- The injured person, as **owner** or registrant of the vehicle, is **uninsured**.
- The driver or passenger of a **stolen vehicle** is injured, when he/she is aware that the vehicle was stolen [3113(a)]
- The vehicle was taken **without permission**, unless it is believed there was *implied permissive* use; i.e., they had taken the car in the past without specific permission
- The injured occupant, if the owner of the vehicle, was **not a resident** of Michigan, and the vehicle was **not registered in Michigan** and **not insured by a company licensed to write no-fault insurance** in the state
- The injured person was a driver **fleeing** from the police

- The accident was the result of the injured person inflicting **intentional** injury to himself/herself

WHO IS ELIGIBLE FOR NO-FAULT BENEFITS?
Conditions that govern the availability of no-fault benefits are explained below.

- **Occupant of a motor vehicle** (driver, passenger)
  - If the occupant of the vehicle is the **owner** [3114] of the vehicle, he/she **must** have auto insurance on that vehicle to be eligible for no-fault benefits. Anyone driving or riding in their **own uninsured vehicle** [3113(b)] is not eligible to receive these benefits.
  - If the occupant of the vehicle is **not** the **owner**, no-fault benefits are available. It is then necessary to follow the order of priority to determine the responsible insurance carrier.

- **Non-occupant of a motor vehicle**
  - Non-occupants of a motor vehicle involved in an auto accident **are entitled** to no-fault benefits. Examples of a non-occupant would be a pedestrian, bicyclist, or the operator of a moped.

- **Motorcycles**
  - **It is necessary to scrutinize <u>all</u> facts regarding a motorcycle accident before the right to no-fault benefits for individuals injured while driving/riding on a motorcycle can be established.** Under the Motor Vehicle Act of Michigan, a *motorcycle* is **not** considered a *motor vehicle* and is **not** covered under the no-fault law. Specific criteria **must** be met for benefits to be available to the injured person.
  - A "motor vehicle" **must** [3114] be involved in the accident for the driver and/or passenger of the motorcycle to be eligible for benefits. Actual physical contact with the motor vehicle is not required; however, the motor vehicle must contribute to the cause of the accident. The injured **owner** of the motorcycle **<u>must</u>** have *liability insurance* on the motorcycle to qualify for PIP benefits [3101, 3103]. The non-owner/driver or passenger is eligible for PIP benefits regardless of whether or not the motorcycle is covered by liability insurance.
  - Medical coverage *may* be available through a liability policy on a motorcycle, however, the owner is *not required* to carry this coverage and *few cyclists have such coverage.* Refer to the general liability section of this manual for the possible resolution of a motorcycle accident liability claim.

WHAT BENEFITS ARE COVERED?

No-fault PIP benefits cover a wide range of expenses incurred by the injured person, both medical and non-medical. It should be noted that charges from providers must be reasonable and services or products, necessary. The No-Fault Law defines a reasonable charge as an amount that does "not exceed the amount the person or institution customarily charges for like products, services and accommodations in cases not involving insurance."

The following is a list of standard covered medical and non-medical benefits. **All benefits are lifetime benefits except for replacement services.**

- **Traditional medical expenses**

  Emergency room treatment, inpatient hospitalization, office visits, physical therapy, outpatient surgical procedures, orthopedic devices, prescriptions, nursing home care

- **Medical transportation costs**

  Ambulance, personal mileage to and from medical care

- **Vocational rehabilitation**

  Occupational retraining, vocational rehabilitation, counseling, and re-education are covered benefits that must be assessed on a case-by-case basis.

- **In-home medical care**

  In-home medical care is a covered benefit where warranted. These services do not need to be performed by trained medical personnel and can be performed by friends or family members if they can adequately perform them.

- **Pre-existing conditions**

  Treatment for pre-existing conditions is a covered no-fault benefit if the accident exacerbates the pre-existing condition.

- **Replacement services** (3 year benefit maximum, $20.00 per day)

  A person injured in an automobile accident may recover expenses incurred for hiring someone to do chores and services (i.e., housecleaning, household maintenance) that the injured person was able to do for himself/herself prior to the accident.

- **Residential/special accommodations**

  In-home structural modifications for a person disabled as a result of an automobile accident are a covered benefit. These modifications could include, but are not limited to, ramps, handrails and specialized bathroom equipment. Additional special accommodations would include the purchase of a van or modifications to a vehicle to enable an otherwise disabled person to continue driving and/or being transported. Other expenses related to the cost of accommodations for the care of the injured person might include food and related expenses for an institutionalized individual.

LIMITATION OF ACTIONS FOR A NO-FAULT AUTO CLAIM

There are specific rules and regulations (outlined below) that must be followed by the no-fault carrier and the injured person when a claim for no-fault benefits is filed**. If these rules are not closely followed, the injured person may lose all rights to recovery of his/her no-fault benefits.** Note: Under the no-fault law, the insurance company has the responsibility to respond within 30 days of receiving a claim [3142].

- **One year notice rule [3145]** (statute of limitations)
  The No-Fault Law requires an injured person or someone on his/her behalf (the QHP or provider as subrogee) to submit **written notice** in the form of an **Application for Benefits** (addendum H) to the liable no-fault carrier, as determined by the order of priority, **within one year** of the date of the accident. ***If written notice is not provided within this one-year period, the injured person loses all rights to recover any PIP benefits***. The required information must include:

  - Name of claimant
  - Address of claimant
  - Location of accident
  - Nature of injury

- **One year back rule [3145]**
  All bills must be presented for payment to the insurance company within one year of the date of service, otherwise all rights to recovery are forfeited.

- **Tolling the Statute of Limitations**
  The statute of limitations may be **tolled (suspended)** under the following circumstances. Additional legal circumstances may allow for exception to the limitations of the statute; legal advice is recommended.

  - **The Lewis Decision** – The statute of limitations is tolled during the time a request for payment is received until the insurance company formally denies payment of that expense. See Lewis v DAIIE, 426 Mich 93 (1986)

  - **Tolling for Minors** – The statute of limitations is tolled for minors until they reach their 19th birthday. See Manley v DAIIE, 127 Mich App 444 (1983)

  - **Mental Incompetency** – The statute of limitations is tolled based upon the mental incompetency of the injured person. See Hartman v INA, 106 Mich App 731 (1982)

  - **Discovery of Injury** – The statute of limitations is tolled until it is determined the medical condition is related to the auto accident. See Kalata v Allstate, 136 Mich App 550 (1984)

"OUT-OF-STATE" ACCIDENTS

No-fault benefits are **payable** for injuries sustained in **accidents occurring outside the State of Michigan** [3111], regardless of the state in which the accident vehicle is registered. Specifically, accidents occurring anywhere in the United States, its territories and possessions, or Canada are covered **if**:

- The injured person was a "named insured" under a Michigan no-fault policy, **or**
- His/her spouse was a "named insured" under a Michigan no-fault policy, **or**
- A relative living in the same household with the injured person was a "named insured" under a Michigan no-fault policy, **or**
- The owner of the vehicle involved in the accident was insured under a Michigan no-fault policy

Under certain circumstances, no-fault benefits **are payable** for injuries sustained to **non-Michigan residents** when the **accident occurs in Michigan**. If an out-of-state vehicle is involved in an accident while in Michigan, and that vehicle is insured by a company that writes no-fault coverage in Michigan, no-fault benefits are available.

COORDINATION OF BENEFITS [3109a]

Medicaid, through its QHPs, is the **payer of last resort**. Medicaid is **not** health insurance but rather an entitlement program for individuals meeting specific eligibility requirements. It should *never* be considered *primary* coverage. Medicaid will pay for benefits **only** after all other possible resources have been exhausted, including the Assigned Claims Facility.

Coordination of benefits involves one or more insurance companies responsible for the payment of medical expenses resulting from an automobile accident. The no-fault law states that no-fault insurance policies must be available with coordination of benefits through **health coverage.** Employer paid sick time **is not** regarded as health coverage and therefore cannot be considered as a coordinated benefit. Consideration **must** be given to the following potential sources of health benefits and no-fault coverage:

- **Private health insurance** is **primary to no-fault coverage** and should be coordinated with no-fault benefits, whenever possible. The no-fault carrier will only be responsible for the portion of the loss not covered by other insurance.

- **Deductibles** for no-fault coverage can only be applied to benefits payable to the insured, the spouse of the insured, or any relative living in the same household as the insured. Medicaid or the QHP is responsible to pay the deductible when it is a condition of the no-fault policy.

NO-FAULT PRIORITIES

To determine the order of priority, or which insurance company is liable to pay PIP benefits, various situations regarding family make-up, vehicle ownership, and accident causes must be closely scrutinized. The **first** order of priority is the injured person's **own no-fault insurance.** If none is available, the second order of priority is the no-fault policy of a family member living in the same household (resident relative). Exceptions: 1) If an **employer's** vehicle is involved, the employer's no-fault insurance is the first priority when the injured person is an employee, employee's spouse, or employee's resident relative; and 2) when the injured person is a driver/passenger on a motorcycle.

When insurance is not available directly through a policy of the injured person, resident relative or employer, the statute creates an order of priority depending upon whether the injured person was an occupant or non-occupant of a vehicle. If more than one insurance policy is available, there will be a shared risk for the claim and a claim must be filed with each company. Examples of shared risk include:

- The injured person does not have a no-fault policy for himself/herself, but may have access to **more than one** policy through relatives living in the same household.
- A pedestrian who does not have a no-fault policy for himself/herself when struck by **more than** one vehicle.

STATUTORY PRIORITY SYSTEM [3114, 3115]

Payment for accident related medical bills are the responsibility of a QHP <u>only</u> after all of the following priorities have been exhausted.

Occupants of motor vehicles – An injured occupant receives PIP benefits according to the following descending order of priority. **Reminder – any person driving or riding in their *own uninsured vehicle* is not eligible to receive PIP benefits.**

1. The injured person's <u>own</u> no-fault policy; **if none**,
2. The no-fault policy of the injured person's <u>spouse or resident relative</u>; **if none**,
3. The no-fault policy of the <u>owner</u> of the occupied vehicle; **if none**,
4. The no-fault policy of the <u>driver</u> of the occupied vehicle; **if none**,
5. Private health insurance for the injured person [3172(2)], **if none**,
6. The Assigned Claims Facility [3172(1)].

Special rules for occupants

- An occupant of an **employer's** vehicle obtains PIP benefits through the employer's no-fault insurance. If the injured person is the **employee in the course of employment**, workers' compensation benefits will be primary over no-fault insurance.

- An occupant/passenger in a non-commercial **bus** (such as a vehicle used by a public mass transit company) or **taxi** seeks PIP benefits first from his/her own insurance or that of a resident relative. If unavailable, PIP benefits are provided by the insurer of the bus or taxi. If the injured person is a passenger on a **commercial** bus, the insurance carrier for the commercial line is primary.

Non-occupants of a motor vehicle - A non-occupant (pedestrian, bicyclist, operator of a moped) injured as the result of an auto accident receives PIP benefits according to the following descending order of priority.

1. The injured person's own no-fault policy; **if none**,
2. The no-fault policy of the injured's spouse or resident relative; **if none**,
3. The no-fault policy of the owner of the vehicle involved in the accident; **if none**,
4. The no-fault policy of the driver of the vehicle involved in the accident; **if none**,
5. Private health insurance for the injured person [3172(2)], **if none**,
6. The Assigned Claims Facility [3172(1)]

Motorcyclists injured in an accident involving a motor vehicle (car, truck, etc.) obtain PIP benefits from the insurance company of the **motor vehicle(s)** involved in the accident as the first order of priority. This is true even though the motorcyclist may have no-fault insurance coverage through his/her own personal motor vehicle. It is important to note that if the **owner** of the motorcycle is the injured party, he/she **must have liability insurance** on the motorcycle to be eligible for the no-fault benefits. When liability insurance is available, the order of priority is as follows:

1. The **owner** of the **motor vehicle** involved in the accident; **if none**,
2. The **driver** of the **motor vehicle** involved in the accident; **if none**,
3. The **driver** of the **motorcycle** involved in the accident; **if none**,
4. The **owner** of the **motorcycle** involved in the accident; **if none**,
5. Private health insurance for the injured person [3172(2)], **if none**,
6. The Assigned Claims Facility [3172(1)]

THE ASSIGNED CLAIMS FACILITY [3172]

The No-Fault Law established the Assigned Claims Facility to provide PIP benefits to individuals involved in an automobile accident when there is *no other* source of personal protection, health, or accident insurance available to them, providing they were not driving or riding in their own uninsured vehicle. It also provides PIP benefits when the identified insurance company is unable to fulfill the financial obligation relative to the injury sustained in the accident.

The Assigned Claims Facility is also responsible for handling claims when there is a dispute between two or more insurers that may be liable for payment of PIP benefits. The claimant or one of the insurers can file a claim with the facility to protect the injured person from legal expenses and from delays in coverage until the issue of priority can be resolved.

WORKERS' COMPENSATION

INTRODUCTION

Workers' compensation is an insurance system set up to provide benefits to employees who have suffered a work-related injury or illness and to protect employers from costly litigation over such claims. It is the oldest form of "no-fault" insurance: benefits are paid without regard to fault for an injury or illness sustained while working.

The Workers' Disability Compensation Act of 1969 established rules and guidelines which must be legally adhered to by most employers in Michigan. These rules define the rights and responsibilities of the employer and employee when an individual is injured while working. The employer is responsible to provide workers' compensation benefits when an individual is injured during the course of employment, even if he/she is involved in an automobile accident while "on the job."

When workers' compensation insurance is available and an employee is injured while working, the employer or employee originates a claim. Occasionally, an employer does not have the required insurance coverage and may be subject to legal action for the recovery of medical and wage loss benefits (see Employer's Liability section).

Workers' compensation insurance benefits are ***primary*** benefits, providing a source of revenue that ***must*** be utilized, whenever available. **Medicaid is the payer of last resort** in accordance with Title XIX of the Social Security Act and Federal Regulation 42 CFR 433.138-433.139.

Health plans, under provisions of the contract with the State, ***will be payers of last resort*** and are contractually obligated to pursue payment for work-related injuries from workers' compensation insurance carriers whenever benefits are available. The initial patient interview should reveal the injury or illness to be work-related and prompt the provider to inquire about a claim. If a workers' compensation claim has been established, it is necessary for the provider to bill the carrier for all work-related treatment.

Pursuant to Medicaid policy, if a claim has been filed and is contested or liability is in question, the QHP must pay for the service and use the "pay and chase" method to pursue recovery from the third party (addendum G)**.**

This section provides basic workers' compensation claim information and defines the responsibility of the QHP to pursue these benefits.

FILING A WORKERS' COMPENSATION CLAIM

It is the responsibility of the *employee or his/her legal guardian* to report any work-related injury or illness to the employer immediately. If the injury results in death, a specific loss, or a disability of seven days or more, the *employer* is required to report that injury to the Bureau of Workers' Disability Compensation on Form 100 (addendum I). If the employer refuses to complete this form, the employee has the right to file Form 117 (addendum J) with the Bureau, on his/her own behalf.

When a workers' compensation claim is filed with the employer and/or insurance company, medical benefits may be available and all work-related medical expenses should be billed directly to the employer or liable insurance company. If a claim has not been filed and the insurance company is unknown to the employee, it can be identified by direct contact with the Bureau of Workers' Disability Compensation, Insurance Division, at (517) 322-1885, or by writing the Bureau at:

Bureau of Workers' Disability Compensation
Insurance Division
PO Box 30016
Lansing, MI 48909

DENIED OR CONTESTED CLAIMS

Provisions in the Workers' Disability Compensation Act allow an insurance company to discontinue benefits for an employee based on an independent medical exam. If benefits are denied, disputed, discontinued or not provided by the employer, it is the responsibility of the employee to pursue legal action to receive or reinstate benefits.

If a case is in dispute, the provider can obtain information and a current status of the case by writing to:

Bureau of Workers' Disability Compensation
Claims Processing Division
PO Box 30016
Lansing, MI 48909

The QHP is required to "pay and chase" expenses when a claim is disputed, denied or benefits are discontinued. QHPs have the authority to intervene in the action with the plaintiff's attorney as a party to the action, or retain independent counsel.

GENERAL LIABILITY

INTRODUCTION

General liability claims are initiated as the result of a wide range of circumstances and/or events that have led to a personal injury or death. Liability is often not immediately established, therefore, the "pay and chase" method of recovery may be required.

Many times the provider will not be aware of a potential or existing claim/lawsuit that might result in the reimbursement of medical expenses directly related to a specific incident. A subpoena requesting medical records and copies of expenditures may be the first notice of a pending lawsuit. Additional sources of information concerning the possible existence of a claim include requests for medical records and/or expenses from an attorney, insurance company, or the beneficiary.

Medicaid is the payer of last resort in accordance with Title XIX of the Social Security Act and Federal Regulation 42 CFR 433.138-433.139. ***Health plans****, under provisions of the contract with the State,* ***will be payers of last resort.*** To ensure appropriate utilization of state and federal funds, it is imperative to pursue all available resources.

This section addresses the different types of liability claims and their potential for recovery.

LIABILITY CLAIMS

Liability is the legal obligation to make good for any loss or damage. When liability pertains to medical coverage, an individual, corporation, or public entity may be legally liable for bodily injury sustained on their premise or from the use of their product. A physician or hospital may also be alleged to be liable for medical malpractice. There may be multiple defendants and/or multiple actions, so it is necessary to identify **all parties** to **all actions** initiated as a result of the injury. Different types of liability claims will be addressed in this section.

The person claiming harm, or his/her personal representative, must initiate all claims. Personal and commercial liability policies often have medical benefits available; the QHP, or its providers, may direct bill for this. **Pursuant to Medicaid policy, if a claim has been filed and is contested or liability is in question, the QHP must pay for the service and use the "pay and chase" method to pursue recovery from the third party** (addendum G).

PERSONAL LIABILITY

An individual injured on someone else's private property, when not the injured person's place of residence, may be entitled to medical benefits through a homeowner's policy. This policy is **primary** to the QHP. Homeowner policies generally contain a maximum medical benefit clause. It may become necessary for the injured person or his/her representative to seek legal representation to receive medical benefits along with liability benefits when liability is proven. The QHP can assert a lien for reimbursement of paid expenses, after the beneficiary initiates the claim, or submit bills for direct payment.

EMPLOYER'S LIABILITY

If an employee is injured while working, and the employer does not have workers' compensation insurance, the employee has the right to pursue medical benefits by filing a personal injury lawsuit. In order for the QHP to be compensated for medical expenses in this instance, it will be necessary to intervene in the action with the plaintiff's attorney or retain independent counsel.

COMMERCIAL LIABILITY

A **premise liability** claim is made against the owner and/or renter of a commercial business when an individual is injured while on the property. Liability insurance may be available to cover *immediate* medical care for such an injury along with liability benefits, *if* liability is proven. The injured person or his/her representative must initiate all claims or litigation. If a claim is denied, or further awards are sought, legal action to pursue such compensation must be initiated by the injured person.

A **product liability** claim can be made individually or collectively against the retailer, wholesaler, or manufacturer of a product alleged to have caused harm. Medical benefits are paid from a liability insurance policy. The injured person or his/her representative may initiate legal action.

MEDICAL MALPRACTICE

Medical malpractice claims are initiated by the injured person or a representative on their behalf, for injurious or unprofessional treatment, or neglect by a physician. Litigation is required for the majority of these cases and legal representation by the QHP may be required for optimum compensation.

RESTITUTION / TRUSTS

District, circuit, and probate courts occasionally order **restitution** as part of the sentence for an individual convicted of a crime. This can take the form of payment for medical expenses incurred as the result of an injury sustained during the criminal activity. The court will notify the QHP, through a probation officer, of the awards and may request documentation to substantiate services received.

Private **trusts** may allow for repayment of medical expenses for an individual. If the existence of a trust becomes known, benefits are presumed available and a request for payment must be directed to the trustee. If the trustee denies payment, it will be necessary to seek legal advice.

MOTORCYCLE LIABILITY

If the owner of a motorcycle has liability insurance on the cycle, medical coverage may be available. Bodily injury coverage is also available for a *passenger* under the liability portion of the policy. A PIP claim should be filed with the appropriate no-fault carrier (see No-Fault Law section, Motorcyclists) and if payment is not forthcoming, it may be necessary for the injured person to initiate legal action.

A person injured in a motorcycle accident may also have the legal right to file a liability suit alleging negligence or fault against a separate entity to pursue medical benefits. Notice of such a suit could come from the plaintiff's attorney, defense attorney or the patient; legal counsel is recommended.

LEGAL ISSUES

Legal issues inherent with general liability claims may include **negligence, malice, comparative negligence, unprofessional treatment, or fault** (see glossary for definition of terms). Settlement outcomes can be closely correlated to the level of negligence or fault attributed to the cause or source of the injury.

SETTLEMENTS

It is the responsibility of the QHP to take an active role in the investigation and/or resolution of a claim or legal action when medical expenditures may be recovered. **A QHP's interests will not be protected without an active role in the claim.**

Different types of settlements are possible and the amount of *recovery* is often dependent upon the settlement amount. The most prevalent types of settlements are:

- **Nuisance award**: a mutual, out of court settlement between parties, without establishing fault
- **Negotiated settlement**: a mutually agreed upon amount; generally when expenses exceed the award
- **Court ordered award**: a specific, mandated amount; a portion may be identified specifically for repayment of medical benefits

- **Structured settlement**: substantial money awards for a severe injury; intended to protect the future of the injured, often a minor
- **Medicaid Type A trust**: a trust established through the settlement of a liability claim which *mandates* Medicaid as the *first* party in the disbursement of the trust

A guideline used within DCH, Revenue and Reimbursement, for negotiating settlements with attorneys or insurance companies is included in this manual (addendum P).

INVESTIGATING / FILING A CLAIM

Specific information is required of the beneficiary when he/she is filing a claim for medical benefits. Information relevant to the injury that can be used to expedite attempts to recoup medical expenditures may be sought from the injured party, property owner, insurance company or attorney. The following information is necessary to file a claim:

- Injured person's name and social security number
- Date of injury
- Location of the accident
- Nature of the injury
- Liable party (homeowner, property owner, employer, etc.)
- Insurance company, policy number

Obtaining *some* information may lead to the acquisition of additional information. For instance, contact with the property owner might reveal the name of the insurance company and whether or not a claim has been filed. Obtaining a copy of the summons and complaint reveals the date of injury, nature of the injury, alleged liable party, and plaintiff attorney information. When the liable third party is identified, written notification (lien letter) of the claim must be forwarded from the QHP to the appropriate office (attorney, insurance company).

Obtaining the following information is beneficial for filing a claim/asserting a lien when the injured party has retained legal counsel:

- Plaintiff attorney name
- Defense attorney name
- Summons and complaint (medical expenses **must** be included in the complaint for recovery)

PARENTAL LIABILITY

INTRODUCTION

Responsibility to pursue **court ordered** Medicaid expenditures associated with the birth of a child remains with the Department of Community Health, Revenue and Reimbursement Division. The cost to the plan for expenses associated with the birth are incorporated into the PMPM; therefore, all moneys collected will be retained by the State. The qualified health plan and their providers have a contractual obligation to support recovery actions by providing expense data and identifying/utilizing all other third party resources. The State must provide childbirth expenses to the Friend of the Court, which in turn will determine the amount to be paid by the father. The procedure for soliciting the court ordered medical support expenses to be reported to the Friend of the Court has yet to be determined.

The liability of the parents for the necessary support for a child born out of wedlock is defined in the Paternity Act 1956 PA 205, as amended; MCL 722.711 (addendum L). The father is liable for expenses in connection with the mother's pregnancy and birth of the child as the court, in its discretion, may deem proper.

It is the responsibility of the QHP and their providers to identify and utilize other health insurance resources for all Medicaid beneficiaries.

RELEASE OF INFORMATION

It is imperative that providers are aware of federal and state regulations related to the use or disclosure of information concerning Medicaid beneficiaries. Federal Regulation 42 CFR 431.300 allows the State to restrict the release of any information concerning Medicaid clients to purposes connected with the administration of the Medicaid program **only**. Under Federal Regulation 42 CFR 431.306(e), policies regarding requests for information from outside sources, including government agencies must be followed in accordance with the State Plan, and "(f) If a court issues a subpoena for a case record... the agency must inform the court of the applicable statutory provisions, policies and regulations restricting disclosure of information."

QHPs AND THEIR PROVIDERS MAY NOT RELEASE A CLIENT'S MEDICAL RECORDS TO ANY UNAUTHORIZED AGENCY OR INDIVIDUAL, INCLUDING THE CHILD'S NON-CUSTODIAL FATHER AND/OR HIS ATTORNEY.

IDENTIFCATION OTHER HEALTH INSURANCE
To effectively pursue payment for expenses associated with the birth of a child, it is imperative to identify all potential insurance coverage(s) for both the mother-to-be and the unborn child with each encounter. Coverage may differ for mother and child.

Possible sources of private health insurance coverage for the mother-to be include:

- If a minor, her parent's private health insurance
- The patient's own private health insurance

Possible sources of private health insurance for the unborn child include:

- If the mother is a minor, her parent's private health insurance
- The mother's own private health insurance
- The father's private health insurance

Most orders of support will require both parents to **obtain, maintain,** and **report** dependent health coverage available to them. If the father enrolls the child at birth on his insurance, birthing expenses and subsequent medical expenses may be covered benefits.

Providers should always question the beneficiary about the availability of additional insurance coverage during the initial and subsequent visits, and update their records on a regular basis. Information regarding other insurance can be obtained from several sources. The State will provide other insurance information to the plans via the enrollment file and remittance advice. For the provider, the beneficiary's Medicaid card will list other insurance (OI) coverage known to the State.

QHPs and their providers should also check the availability of other insurance known to the State by using the dial-up ACCESS phone system (addendum B) or on-line ACCESS program, where available. ACCESS will provide updated insurance coverage with detailed information.

VERIFICATION OF OTHER HEALTH INSURANCE
Insurance information must be verified and documented. The following actions should be taken:

- Obtain policyholder's social security number, full name and birth date
- Obtain copies of the insurance cards (front and back)
- Obtain a copy of the Medicaid card
- Verify coverage and effective dates through the insurance company
- Identify covered and non-covered services available through the policy
- Verify insurance known to Medicaid by using the dial-up ACCESS phone system (1-800-723-8247, addendum B) or on-line ACCESS program where available
- Verify BCBS insurance coverage by accessing the DENIS or HART systems

REPORTING OF OTHER HEALTH INSURANCE
If private health insurance information is obtained that is not indicated on the ACCESS system, it should be reported to the Department of Community Health, Revenue and

Reimbursement Division via form DCH-0402 (addendum A) by mail, e-mail, or fax to the addresses and phone numbers listed on the form. (refer to Data Sharing section)

MAINTAIN ENCOUNTER / COST DATA

Health Plans must be prepared to report, upon request, pre/postnatal, labor and delivery expenditures for specified Medicaid clients. Providers should be prepared to gather and document expenses for mother and child as follows:

- The **mother's** obstetrical expenses for 9 months prior to delivery through 3 months after the delivery date. Example: For a delivery date of 4/10/98 the billing date parameter would be 7/1/97 through 7/1/98.

- The **child's** total expenses incurred from birth through hospital discharge.

There are unique circumstances to consider regarding submission of expenditures. These may include, but are not limited to, the following:

- If a child is **transferred** from one hospital to another under the same admission, include charges from both hospitals. If the second hospital is designated as a *new admission* and *not* a part of the birthing process, do not use the second hospital admission.

- **Sterilization** performed while the mother is in the hospital is a covered expense; however, this charge is ***not*** included in the *associated childbirth* expenses.

- A **multiple birth** is considered one birthing expense for the mother. Hospital and physician charges are handled separately for each of the children.

DATA SHARING

The Revenue and Reimbursement Division serves as a repository of data to assist QHPs and their providers in identifying and pursuing payments from liable third parties. This information includes private health insurance and potential casualty cases**.**

Basic health coverage is provided to QHPs at the point of enrollment with more detailed data included on the monthly remittance advice. In addition, QHPs receive information regarding new casualty cases identified by the Revenue and Reimbursement Division. QHPs and their providers will use this information to initiate action and/or update their own databases.

The State utilizes a variety of sources to maintain a third party liability database. Under managed care, QHPs must play a progressively larger role in assisting with updating this data. Because beneficiaries move among QHPs or between managed care and fee-for-service, all parties benefit from the availability of current data.

This section describes information available to the QHPs and their providers. It also presents ways the plans and their providers can assist the Revenue and Reimbursement Division in maintaining information that is both accurate and current.

COMMERCIAL HEALTH INSURANCE

QHPs and providers must inform the Revenue and Reimbursement Division of changes to, or additional health coverage identified for a Medicaid enrollee. This can be accomplished via form DCH-0402 (addendum A). When submitting private health insurance information to the State, it is necessary to identify the QHP, QHP contact person with phone number, and the Medicaid beneficiary name and ID number. The following additional information must also be submitted:

- Commercial insurance carrier name
- Policyholder's name
- Policyholder's social security number
- Policy/group number
- Effective dates of coverage
- Employer name
- Name(s) and Medicaid ID number(s) of others covered by this contract

It is also important to notify the State when a Medicaid beneficiary is known to be concurrently enrolled in a Medicare HMO.

Private health insurance information retained by the State is available from the following sources:

- Remittance Advice transmitted for each Medicaid payroll via tape or the 1232 electronic version. This file includes other insurance information with the informational edit 271 (HMO/Clinic plan beneficiary has other insurance.) and includes the carrier name, contract number, policy/group number and service codes.
- FM089 Monthly Enrollment tape or the 3653 Monthly Enrollment/Disenrollment file through the Data Exchange Gateway (DEG)
- 4276 Daily Enrollment file from Michigan Enrolls
    - ACCESS dial-up or online system. All health insurance information known to the State will be available through this system. When using the dial-up program, it is

important to complete the series of prompts (i.e., do not stop after hearing the OI code) to get an accurate picture of the beneficiary's complete insurance coverage.

Note: The monthly and daily enrollment files include only one OI code which CIS updates monthly. This OI code is selected based on an established priority system and may not reflect all health insurance coverage available to the beneficiary.

CASUALTY

When QHPs and their providers identify the existence of a potential casualty case, it is necessary to report this information to the State. This can be accomplished via form DCH-0674 (addendum S). Up-to-date casualty information is critical for the protection of **all** parties with an interest in crossover cases. When submitting information about a casualty case, provide the following elements:

- Beneficiary name and Medicaid ID number
- Type of accident
- Date of accident/incident
- The injury related to the accident/incident
- Attorney name, address and phone number

If the accident is motor vehicle related, the following information is required:

- Location of accident
- Indicate if beneficiary was the driver, passenger, pedestrian, other
- Type of vehicle involved
- The beneficiary's auto insurance company/agent, address, phone number, policy/claim number
- If the beneficiary was uninsured on the date of the accident, provide the name of a relative living with the beneficiary on that date and his/her insurance company/agent, address, phone number, policy/claim number
- If the beneficiary was a passenger, pedestrian, bicyclist, or driving/riding a motorcycle, provide the beneficiary's own insurance information **and** the name of the owner/driver of the vehicle with their insurance company/agent, address, phone number, policy/claim number

If the injury is work-related or another type of injury with the potential for a liability claim, it is necessary to obtain the name of the employer, property owner or other responsible person. Include any known insurance company, address, phone number and claim number.

The Revenue and Reimbursement Division will identify and forward to the plans, leads from attorneys, insurance companies, subpoenas, and the beneficiaries. An informational letter regarding the request will be sent with pertinent information known to the Division for appropriate action by the plan.

Plans will be notified of crossover cases identified by the Revenue and Reimbursement Division and will include the following information:

- Beneficiary name and Medicaid ID number
- Type of accident/incident
- Date of accident
- Type of injury
- Insurance company, phone number, adjuster name
- Claim number
- Attorney information
- DCH claimed and recovered amounts to date
- Any additional pertinent information relevant to the claim

PARENTAL LIABILITY

Unlike other categories of third party liability, the State has retained responsibility for recovering court ordered childbirth-related expenses paid by Medicaid. QHPs have a contractual obligation to support the recovery process by providing the necessary data.

Expenses associated with the birth of a child include (1) the mother's antepartum, labor, delivery and postpartum expenditures incurred for the period 9 months prior and 3 months following the delivery date; and (2) **all** expenses accrued for the child from birth through hospital discharge.

The State is considering the following four options for providing this information to the Friends of the Court:

1. Require QHPs to submit actual cost or charge information; **or**
2. Require QHPs to provide encounter data which could be matched against Medicaid fee screens; **or**
3. Use charges structured on a regionally based average cost per case. This approach would require the acquiescence of judges, prosecutors, FIA's Office of Child Support and the Friend of the Court; **or**
4. All, or a portion of, a year’s capitation rate

Until a decision is made regarding a method to address court ordered medical support expenditures, requests may be received from the State to provide information for specified clients (see Parental Liability section).

FORMATS FOR SUBMISSION OF REQUESTED INFORMATION

The Revenue and Reimbursement Division is prepared to receive requested information via mail, e-mail or fax. When submitting data, the following formats may be used:

- Word/WordPerfect
- Excel/QuatroPro
- Text file (.txt) delimited or fixed width
- Commercial Insurance Information form DCH-0402 (MS Word 97 required for electronic submission)
- Casualty Case Information form DCH-0674 (MS Word 97 required for electronic submission)

Mail requested information to:

Michigan Department of Community Health
Revenue and Reimbursement Division
PO Box 30053
Lansing, MI 48909

Fax information to: Revenue and Reimbursement Division (517) 335-8868

e-mail information to: TPL@STATE.MI.US

RESOURCES

SUPPORT SERVICES AVAILABLE FROM THE STATE

A variety of support services are available from the Revenue and Reimbursement Division. This division is composed of staff with extensive experience and expertise in all facets of third party liability. They have handled third party functions for many years under the fee-for-service structure, and are now responsible for ensuring that these functions are effectively maintained within the managed care environment.

Responsibility for billing private health insurance (coordination of benefits) and recovery of casualty claims rests with qualified health plans (QHPs) and their providers. Plans that actively pursue TPL are likely to realize a significant financial gain.

Three specific ways in which Revenue and Reimbursement will work to maximize your ability to pursue third party resources include:

1. **Training**

   Training responsibilities include maintaining and updating the training manual and the provision of on-site training for plans and/or their providers, when requested by a QHP. The purpose of on-site training is to enhance and supplement information contained in this manual. In addition, an easy to read brochure (addendum T) has been developed for Medicaid beneficiaries explaining third party liability and beneficiary responsibility to reveal and utilize third party resources.

2. **Technical Assistance/Consultation**

   Division staff are available to QHPs for technical assistance relating to third party functions/issues and assistance with individual cases. Staff will provide consultation regarding third party liability policy issues and your plan's existing procedures.

3. **Data Sharing**

   Data sharing services are available to assist QHPs with third party efforts. The Division can provide lists of beneficiaries identified as having other insurance, although some of this information is available at the point of enrollment and from the monthly remittance advice.

   Plans are provided with information regarding potential casualty claims involving their Medicaid enrollees. In addition, a database of Medicaid beneficiaries known to have current and closed casualty claims is maintained by the Revenue and Reimbursement Division. Upon request, this information will be shared with QHPs to initiate action and/or update their own database.

   Due to overlapping interests, the State intends to take the lead in the pursuit of claims involving casualty crossover cases. Division staff will continue to pursue claims for services provided when a beneficiary was served under fee-for-service.

WHO TO CONTACT

The following individuals may be contacted for assistance in the area of business designated:

Business Area	Name	Phone Number	E-mail
Casualty Cases	Donna Durbin	517-335-8021	DurbinD@STATE.MI.US
Health Benefits	Mark Verleger	517-335-8213	VerlegerM@STATE.MI.US
Commercial HMO/PPO	Carol Eby Kathy Sellers	517-335-9412 517-335-9726	EbyC@STATE.MI.US SellersK@STATE.MI.US
Medicare COB	Liz Torres	517-335-9085	TorresE@STATE.MI.US
Parental Liability	Rosie Line	517-335-8002	LineR@STATE.MI.US
Data Sharing	Cynthia Green-Edwards	517-335-8474	EdwardsC@STATE.MI.US
Manual Updates	Victoria Martinez	517-335-9427	MartinezV@STATE.MI.US
General Questions	Jackie Pirie	517-335-8573	TPL@STATE.MI.US

WEB SITES

The following is a list of Web Sites, which can provide additional information regarding third party liability and related matters:

Michigan No-Fault Law – http://www.cis.state.mi.us/ins/

Workers' Compensation Law – http://www.cis.state.mi.us/wrkcomp/home.htm

Medicare/Medicaid – http://www.hcfa.gov

Social Security Act – http://www.hcfa.gov/regs/ssasect.htm

Code of Federal Regulations – http:www.access.gpo.gov/nara/cfr/index.html

Michigan Compiled Laws/Public Acts – http://www.michiganlegislature.org

FREQUENTLY ASKED QUESTIONS

Q: What if a beneficiary is uncooperative with regard to identifying/pursuing private insurance?

A: A condition of eligibility for Medicaid is that a beneficiary **must** identify all third party resources. If he/she fails to provide this information or does not cooperate in filing the necessary claim, you may contact The Department of Community Health, Revenue and Reimbursement Division (refer to Resources section), and we will follow-up with the caseworker and/or beneficiary.

Q: Is it necessary for the QHP to "pay and chase" recoveries?

A: Yes, in certain situations. This will be necessary in the case of liability claims and/or lawsuits and occasionally for auto and workers' compensation claims if there is a dispute regarding payment. If health coverage is identified after services have been provided, a process should be established to ensure that the network provider or the QHP bill the appropriate carrier for the service.

Q: Does the QHP have the right to subrogation?

A: Yes. Pursuant to Section 106 of The Michigan Social Welfare Act, MCLA400.106; MSA16.490 (16), the State of Michigan has full subrogation rights. The QHP, as the managed care provider for the State, also has the right to subrogation.

GLOSSARY

Arbitration: A form of alternative dispute resolution where an unbiased person or panel renders an opinion as to responsibility for or extent of loss.

Aggravation: Make more serious, intensify

Assigned Claims Facility: A plan established by the State of Michigan to provide financial help to people injured in an uninsured motor vehicle accident, who have no insurance coverage of their own. The Facility is administered by the Department of State, under authority of the No-Fault Insurance Law.

Automobile Liability Insurance: Protection for the insured against financial loss because of legal liability for car-related injuries to others or damage to their property.

Benefits: The amount payable by the insurance company to a claimant, assignee or beneficiary under each coverage.

Bicycle: A device propelled by human power upon which a person may ride, having either 2 or 3 wheels in a tandem or tricycle arrangement, all of which are over 14 inches in diameter.

Casualty Insurance: Insurance benefits that cover the insured's legal liability for injuries to others or damage to other person's property.

Certificate of Insurance: A statement of coverage issued to an individual insured under a group insurance contract, outlining the insurance benefits and principal provisions applicable to the member.

Claim: A request for payment of a loss which may come under the terms of an insurance contract.

Coinsurance: 1) a provision under which an insured who carries less than the stipulated percentage of insurance to value, will receive a loss payment that is limited to the same ratio which the amount of insurance bears to the amount required; 2) a policy provision frequently found in medical insurance, by which the insured person and the insurer share the covered losses under a policy in a specified ratio, i.e., 80 percent by the insurer and 20 percent by the insured.

Commercial Vehicle: "Commercial vehicle" includes all motor vehicles used for the transportation of passengers for hire, or constructed or used for transportation of goods, wares or merchandise, and/or all motor vehicles designed for drawing other vehicles and not so constructed as to carry any load thereon either independently or any part of the weight of a vehicle or load so drawn.

Comparative Negligence: Where two or more parties contribute to an injury. Recoveries are reduced by the percentage of the negligence.

Confinement Expenses: Hospitalization and pre/postnatal expenses.

Coordination of Benefits (COB): The mechanism used in group health insurance to designate the order in which the multiple carriers are to pay benefits and to prevent duplicate payments.

Crossover Case: A case involving an active casualty claim for a beneficiary who transitions between fee-for-service and QHP(s).

Death Benefit: A payment made to a designated beneficiary upon the death of the insured.

Deductible: An amount, which a policyholder agrees to pay, per claim or per accident toward the total amount of an insured loss.

Dual Eligible: Concurrently eligible for Medicaid and Medicare.

First Party Coverage: An insurance coverage under which the policyholder collects compensation for losses from the insured's own insurer rather than from the insurer of the person who caused the accident.

General Liability Insurance: Coverage that pertains, for the most part, to claims arising out of the insured's liability for injuries for damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, and the operation of machinery, as well as professional services.

Health Insurance: Insurance against financial losses resulting from sickness or accidental bodily injury.

Health Maintenance Organization: An organization that provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Intervene: To join in litigation to protect one's claim.

Irrevocable Trust: A trust in which the creator does not reserve the right to reacquire the trust property.

Lapsed Policy: A policy terminated for non-payment of premiums.

Leased Vehicle: A motor vehicle for which a person is granted possession for a contracted period of time and in return for a contracted sum.

Liability Insurance: 1) Insurance covering the policyholder's legal liability resulting from injuries to other persons or damage to their property. 2) Provides protection for the insured against loss arising out of legal liability to third parties.

Malpractice: Improper care or treatment by a physician, hospital, or health care provider

Medicaid: State programs of public assistance to persons whose income and resources are insufficient to pay for health care. Title XIX of the Federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare: A program of Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B) protection provided under the Social Security Act.

Moped: A 2- or 3-wheeled vehicle powered by an engine of 50 cc or less which cannot propel the vehicle at a speed greater than 30 miles per hour.

Motor Vehicle: A vehicle propelled by a self-contained engine and designed to travel on ordinary roads.

Motorcycle: A two-wheeled vehicle powered by an engine of more than 50 cc. having a saddle or seat for the use of the rider and designed to travel on not more than 3 wheels in contact with the ground.

Negligence: Failure to use the care that a reasonable and prudent person would have used under the same or similar circumstances.

No-Fault Automobile Insurance: A form of insurance by which a person's financial losses resulting from an automobile accident are paid by his or her own insurer regardless of who was at fault.

Occurrence: An accident, including continuous or repeated exposure to substantially the same general, harmful conditions, that results in bodily injury or property damage during the period of an insurance policy.

Pay and Chase: A method used where Medicaid (QHP) pays the beneficiary's medical bills and then recovers from liable third parties.

Pedestrian: Any person afoot

Personal Injury Protection (PIP): First-party no-fault coverage in which an insurer pays, within the specified limits, the wage loss, medical, hospital and funeral expenses of the insured.

Policy: The printed legal document stating the terms of the insurance contract that is issued to the policyholder by the company.

Policyholder: A person (or employer) who pays a premium to an insurance company in exchange for the insurance protection provided by a policy of insurance.

Preexisting Condition: A physical and/or mental condition of an insured which first manifested itself prior to the issuance of his/her policy or which existed prior to the issuance and for which treatment was received.

Primary Insurance: Insurance that pays compensation for a loss ahead of any other insurance coverage the policyholder may have.

Private Health Insurance: Insurance available to a Medicaid beneficiary through an employer or private purchase.

Probate: The court-supervised process of validating or establishing the payment of outstanding obligations.

Product Liability Insurance: Protection against financial loss arising out of the legal liability incurred by a manufacturer, merchant, or distributor because of injury or damage resulting from the use of a covered product.

Proof of Loss: Documentation presented to the insurance company by the insured in support of a claim so that the insurer can determine its liability under the policy.

Punitive Damage: A court-awarded amount that exceeds the economic losses and general damages of a defendant and is intended solely to punish the defendant.

Reasonable and Customary Charges: Charges for health care, which is consistent with the going rate or charged in a certain geographical area for identical or similar services.

Rehabilitation: 1) Restoration of a totally disabled person to a meaningful occupation, 2) a provision in some long-term disability policies that provides for continuation of benefits or other financial assistance while a totally disabled insured is retraining or attempting to resume productive employment.

Reimbursement: The payment of the expenses actually incurred as a result of an accident or sickness, but not to exceed any amount specified in the policy.

Resident Relative: A blood relative that resides in the same residence for a period of more than 30 days.

Restitution: Making good for loss or damage; reimbursement

Revocable Trust: A trust that can be terminated or revoked by its creator.

Self-Insurance: A program for providing group insurance with benefits financed entirely through the internal means of the policyholder, in place of purchasing coverage from commercial insurers.

Settlement Options: The several ways, other than immediate payment in cash, which a policyholder or beneficiary may choose to have policy benefits paid.

Special Damages: Compensation awarded for actual economic losses, such as medical expenses and lost wages.

Subrogation: Process by which one insurance company/agency, or Medicaid, seeks reimbursement from another company or person for a claim it has already paid.

Subrogee: One who succeeds to the rights of another by subrogation.

Third Party Liability: Refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a member's medical coverage.

Time Limit: The period of time during which a notice of claim or proof of loss must be filed. Also referred to as "Statute of Limitations."

Toll: Suspend

Tort: A civil wrong, other than a breach of contract, for which a court of law will afford legal relief, i.e. harming another by an act of negligence in driving an auto.

Trust: A legal instrument allowing one party to control property for the benefit of another.

Workers' Compensation: A system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment.

Workers' Compensation Insurance: Insurance against liability imposed on certain employers to pay benefits and furnish care to employees injured, and to pay benefits to dependants of employees killed in the course of or arising out of their employment.

ACRONYMS

ACCESS	Automated Client Care & Eligibility Support Systems, MI FIA
ACF	Assigned Claims Facility
ALJ	Administrative Law Judge
BCBSM	Blue Cross Blue Shield of Michigan
CFR	Congressional Federal Register, or Code of Federal Regulations
CHAMPUS	Civilian Health & Medical Program of the Uniformed Services
CIS	Client Information System
CMHSP	Community Mental Health Services Programs
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act ’86
CO-DED	Coinsurance and Deductible, Medicare
CSHCS	Children’s Special Health Care Services, prior Crippled Children
CWF	Common Working File computer system, Medicare
DCH	Department of Community Health, MI
DENIS	Dial-in Eligibility Network & Information System
EOB	Explanation of Benefits
ERISA	Employee Retirement Income Security Act, federal, ’74
FFS	Fee-for-service
FIA	Family Independence Agency
FOC	Friend of the Court
FOIA	Freedom of Information and Privacy Act, federal
HART	Hospital Access & Response Terminal
HCFA	Health Care Financing Administration, federal

HCFA 1500	Universal health professional billing form
HCPCS	HCFA Common Procedural Coding System
HEDIS	Health Employer Data Information Service, NCQA, Medicaid
HMO	Health Maintenance Organization
IME	Independent Medical Exam
MA	Medicaid, Medical Assistance
MCL	Michigan Combined Laws
MSA	Medical Services Administration
MSP	Medicare Second Payer
MUPC	MI Uniform Procedural Coding (from CPTs)
NF	No-Fault
OBRA	Omnibus Budget Reconciliation Act, federal, ’81, ’87, ’90, etc.
OCS	Office of Child Support
OI	Other Insurance
PCCM	Primary Care Case Management (HCFA term for MSA PSP program)
PCP	Primary Care Physician
PDR	Physician Desk Reference
PEM	Program Eligibility Manual, FIA
PIP	Personal Injury Protection
PPI	Property Protection Insurance
PPO	Preferred Physician Organization
QMB	Qualified Medicare Beneficiary
QHP	Qualified Health Plan
SSA	Social Security Administration
SSI	Supplemental Security Income

T5, Title 5	Title V, for children with disabilities, Soc. Sec. Act
T18, Title 18	Title XVIII, for people over 65 years of age, Soc. Sec. Act
T19, Title 19	Title XIX, for people who are low income, Soc. Sec. Act.
TPL	Third Party Liability
WC	Workers' Compensation

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